STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	08/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT ST SABETHA, KS 66534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 85 residents. The sample included 14 residents. Based on observation, interview and record review the facility failed to revise the care plan for 1 of 14 residents, (#48) for falls. Findings included: - Resident #48's electronic diagnosis list from the physician's orders last dated 3/5/13 documented the diagnoses of constipation, gastric disease,	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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urinary incontinence and headaches.

The admission Minimum Data Set (MDS) 3.0 dated 12/17/12 documented the resident with a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severely impaired cognition. He/she required supervision with bed mobility, extensive assistance with transfers, walking and dressing and limited assistance with toileting. The resident was not steady moving from a seated to standing position, walking, turning around, moving on and off the toilet and with surface to surface transfers. The resident had impaired upper extremity range of motion on one side and was frequently incontinent of urine and always incontinent of bowel. There was a toileting program used to manage the resident's urinary continence. The resident had a fall in the last month prior to admission. He/she had a fracture related to a fall in the last 6 months prior to the admission.

The Care Area Assessment (CAA) for incontinence dated 12/19/12 documented the resident had a long history of incontinence. He/she was able to recognize the time and place to void, wore pull ups and needed assistance to change the incontinent product. The resident reported he/she did not always make it to the toilet in time.

The CAA for falls dated 12/19/12 documented the resident had a history of falling while in the assisted living. Since admitted to the facility he/she needed assistance to ambulate and was aware of how to use the call light. The resident's room was near the nurse's station.

The quarterly Minimum Data Set 3.0 dated 7/29/13 documented the resident required

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extensive assistance for bed mobility, transfers, ambulation, dressing and toileting. He/she fell twice since the prior assessment.

The care plan for activities of daily living dated 2/14/12 directed staff to provide 1 person assistance with transfers, dressing, grooming and scheduled toileting. The resident had neuromuscular impairment with Parkinson's Disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness) and profound scoliosis (lateral curvature of the spine) and leaned to the left. The facility provided a physical therapy referral to assess his/her gait. Staff reviewed/updated the care plan on 2/11/13 and added self locking wheel chair brakes. On 2/25/13 staff up dated the care plan to reflect the resident was 50 percent weight bearing on the left leg. On 5/10/13 staff added new interventions for staff to keep the call light in reach, administer medications and observe for side effects. The resident had decreased functioning due to a right hip fracture. Staff toileted the resident before and after meals, at bed time and as needed and he/she wore pull ups.

Nurse's notes dated 2/12/13 at 4:15 A.M. documented staff observed the resident on the floor by his/her bed. The resident told staff his/her legs went out and caused the fall. Staff assessed the resident and assisted him/her to the bed. Staff found no injuries at that time. At 10:27 A.M. the resident complained of left thigh, knee and ankle pain. Staff were unclear of exactly what was hurting the resident. The physician was notified and an order was received to X-ray the resident.

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F 280	Continued From page 3 Observation on 8/8/13 at 12:08 P.M. of the nurse's desk revealed a small monitor with a picture of the resident's empty bed. The monitor did not display a picture of the resident who sat in the recliner. Observation on 8/8/13 at 12:44 P.M. revealed the resident sat in the wheelchair in his/her room. Direct care staff T asked the resident if he/she needed to use the toilet. The resident told staff he/she was elderly and did not always know when he/she needed to use the toilet and asked when the next opportunity to toilet would be. Staff informed the resident they would offer to toilet him/her before the next meal. Staff did not offer anymore encouragement to toilet the resident, but instead placed the gait belt around the resident and transferred the resident using extensive assistance and frequent cues to move his/her feet and sit down on the bed. Staff lowered the bed down to the floor. Staff did not place a fall mat by the resident's bed on the floor. During interview on 8/8/13 at 11:34 A.M. direct care staff U reported the resident was unsteady on his/her feet, leaned to one side and liked to do things on his/her own without calling staff for help. The video camera monitor at the nurse's desk was used by staff at night to see the resident while in bed. Staff kept the wheelchair away from the resident so he/she would be less eager to get up without staff assistance. When the resident was in bed, staff lower the bed down to the floor. The resident had self locking brakes on the wheelchair. During interview on 8/8/13 at 11:45 A.M. licensed nurse I reported the resident was high risk for falls, had balance issues, leaned to the left side	F 280		

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F 280	Continued From page 4 and was not aware of safety and frequently tried to transfer independently which caused falls. When a resident fell the nurse assessed the resident and filled out an incident report in the computer and the system made staff put a fall intervention in place before the computer allowed the nurse out of the program. During interview on 8/8/13 at 3:23 P.M. administrative nursing staff D reported staff should lower the bed, use a landing strip mat by the bed and use the monitor/camera at night. Staff needed to put an appropriate intervention in place after each fall. The care plan updated 5/10/13 lacked interventions for the fall landing mat or the monitor at night. The facility provided a policy without a date entitled Care Plans which directed staff to review and revise care plans on a quarterly basis and also as needed when changes occur. The facility failed to timely revise the care plan to reflect the use of a camera monitor which staff carried at night to monitor the resident while in bed and the use of a fall landing strip by the bed.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 5 This Requirement is not met as evidenced by: The facility identified a census of 85 residents. The sample included 14 residents. Based on observation, record review and staff and resident interviews, the facility failed to timely assess one of one (#16) residents reviewed for Dialysis (method to filter your blood of harmful waste). Findings included: - The electronic diagnoses dated 6/20/2012 for resident #16 listed End Stage Renal Disease (a disease condition that was terminal because of irreversible damage to the kidney), Diastolic Heart Failure (symptoms of heart failure with impaired left ventricular function), Morbid Obesity, Anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues), Atrial Fibrillation (rapid, irregular heart beat) and Hypertension (elevated blood pressure). The 8-5-2013 Quarterly Minimum Data Set (MDS) 3.0 documented a Brief Interview of Mental Status score of 14 which indicated the resident was cognitively intact. The MDS documented the resident was on a toileting program or trial. The resident was occasionally incontinent of urine and bowel, had a Urinary Tract Infection (UTI) in the last 30 days, and received dialysis. The Care Area Assessment (CAA) for Activities of Daily Living (ADLs) dated 5-15-2013 documented weakness due to dialysis. The resident needed assistance with ADL's at times and needed greater assist depending on how he/she felt that day. The resident was able to communicate needs with staff. The CAA for Urinary Incontinence/Catheter dated	F 309		

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5-15-2013 documented the resident needed one staff to assist with toileting. Staff helped him/her with transfers, and changed the product and cleansed the resident.

The CAA for Dehydration/Fluid Maintenance dated 5-15-2013 documented the resident was on a fluid restriction due to dialysis. The resident drank an adequate amount of fluid during the day and the UTI was resolved.

The electronic care plan for dialysis dated 6-20-2012 documented the port site was on the left upper arm. Dialysis would weigh and report to the facility. The intervention dated 6-29-2012 documented a fluid restriction of 1600 cc (cubic centimeter) per 24 hours. The intervention dated 6-24-2013 documented staff to check the resident's blood pressure and pulse after returning from dialysis, and staff to chart on the Treatment Administrative Record (TAR). Per dialysis directive, Staff to not remove dressing on left upper arm port site unless dialysis notified the facility staff of a need to do so. Staff to ensure the dressing was intact daily. On dialysis days staff to check the dressing when he/she returned.

Observation on 8-7-2013 at 12:20 P.M. revealed the resident returned from dialysis. further observation to 2:45 P.M. revealed staff did not obtain a blood pressure and pulse from the resident and staff did not assess the bandage site.

The TAR from July 31 st, 2013 to August 7 th, 2013 documented to ensure the dressing was intact to dialysis port site twice a day A.M. and P.M. (on dialysis days check it when he/she returned) with the date of 6-24-13; Noted on TAR staff did not document the PM assessment. Staff

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to check blood pressure and pulse three times a week Monday, Wednesday and Friday in the AM and take the blood pressure and pulse after he/she returned fro dialysis. This same TAR revealed staff did not document the blood pressure and pulse after the resident returned from dialysis.

The electronic nurses notes signed and dated 8-2-2013 documented the resident returned from dialysis at 12:30 P.M. and staff documented the blood pressure and pulse at 2:43 P.M.

On 8-5-2013 staff documented the resident returned from dialysis at 12:30 P.M. and documented blood pressure and the pulse at 1:14 P.M.

On 8-7-2013 at 3:09 P.M. the resident stated he/she was having a good day. He/she was a little sleepy though. Nursing staff did not check his/her site or did his/her vital signs yet. Normally staff would check his/her vital signs at the supper table.

On 8-7-2013 the resident returned from dialysis at 12:20 P.M. and the blood pressure and pulse were not obtained from 12:27 P.M. to 3:09 P.M. per observation and interview.

On 8-7-2013 at 2:15 P.M. direct care staff R stated when the resident returned from dialysis, staff took him/her to the bathroom and staff watched for diarrhea and vomiting. He/she then would ask to be put into his/her chair. CNAs do not monitor the dialysis site. Staff would report anything abnormal with the resident to the charge nurse.

On 8-7-2013 at 2:44 P.M. interview with direct

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care staff S stated when the resident came back from dialysis staff took him/her to lunch then staff would take him/her to their room to the toilet. CNAs do not monitor the dialysis site. Anything abnormal with the resident, direct care staff would notify the charge nurse.

On 8-7-2013 at 3:15 P.M. nursing staff K stated when the resident came back from dialysis staff checked the site and checked for bleeding through the bandage. If he/she was not feeling well we took his/her vital signs. He/she would tell us if something was going on.

On 8-7-2013 at 3:30 P.M. interview with nursing staff L stated when the resident came back he/she went right to lunch. After he/she was done with lunch, I would assess his/her site for drainage. Staff did not weigh him/her. Staff got his/her weight from dialysis. If he/she was feeling sick he/she would let staff know. I monitor him/her for fluid intake also. I do vital signs before he/she went to breakfast. If there was any problems dialysis called or staff called them. There was no communication sheet. Nursing staff stated all I get from dialysis was a pre weight and post weight. I did not talk to them on a daily basis. Communication from dialysis goes through the nursing office.

On 8-7-2013 at 3:55 P.M. interview with administrator nursing staff D stated I expected staff to check the resident back in. There was good communication between dialysis and the facility. Dialysis did his/her weights and staff put them in the computer. Usually staff communicated verbally over the phone or though fax. Dialysis communicated with the charge nurse. I would like vital signs taken when he/she came back but vital signs upon return was not

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F 309	Continued From page 9 consistent. I did not know if staff charted when they check his/her site. When the resident got back I expected staff to check his/her site or follow up when they got a chance. The undated facility policy for Dialysis did not specifically state nursing assessment parameters for before and after dialysis. The facility failed to assess in a timely manner for this resident that received dialysis treatment.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 85 residents. The sample included 14 residents. Based on observation, interview and record review the facility failed to provide appropriate interventions to prevent falls for 1 of 3 residents sampled for accidents, (#48) identified to be at high risk for falls. Findings included: - Resident #48's electronic diagnosis list from the physician's orders last dated 3/5/13 documented the diagnoses of constipation, gastric disease, urinary incontinence and headaches. The admission Minimum Data Set (MDS) 3.0	F 323		

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dated 12/17/12 documented the resident with a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severely impaired cognition. He/she required supervision with bed mobility, extensive assistance with transfers, walking and dressing and limited assistance with toileting. The resident was not steady moving from a seated to standing position, walking, turning around, moving on and off the toilet and with surface to surface transfers. The resident had impaired upper extremity range of motion on one side and was frequently incontinent of urine and always incontinent of bowel. There was a toileting program used to manage the resident's urinary continence. The resident had a fall in the last month prior to admission. He/she had a fracture related to a fall in the last 6 months prior to the admission.

The Care Area Assessment (CAA) for incontinence dated 12/19/12 documented the resident had a long history of incontinence. He/she was able to recognize the time and place to void, wore pull ups and needed assistance to change the incontinent product. The resident reported he/she did not always make it to the toilet in time.

The CAA for falls dated 12/19/12 documented the resident had a history of falling while in the assisted living. Since admitted to the facility he/she needed assistance to ambulate and was aware of how to use the call light. The resident's room was near the nurse's station.

The quarterly Minimum Data Set 3.0 dated 7/29/13 documented the resident required extensive assistance for bed mobility, transfers, ambulation, dressing and toileting. He/she fell twice since the prior assessment.

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F 323	Continued From page 11 The Fall Risk Assessment dated 12/13/12 documented the resident with a fall score of 18, which indicated the resident was high risk for falls. The fall score totals provided by the facility indicated a score higher than 10 represented a resident was high risk for falls. Review of the Voiding Diary dated 12/14/12 revealed staff did not check the resident hourly for incontinence and complete the assessment to establish a voiding pattern indicated on the form. The care plan for activities of daily living dated 2/14/12 directed staff to provide 1 person assistance with transfers, dressing, grooming and scheduled toileting. The resident had neuromuscular impairment with Parkinson's Disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness) and profound scoliosis (lateral curvature of the spine) and leaned to the left. The facility provided a physical therapy referral to assess his/her gait. Staff reviewed/updated the care plan on 2/11/13 and added self locking wheel chair brakes. On 2/25/13 up dated the care plan to reflect the resident was 50 percent weight bearing on the left leg. On 5/10/13 staff added new interventions for staff to keep the call light in reach, administer medications and observe for side effects. The resident had decreased functioning due to a right hip fracture. Staff toilet the resident before and after meals, at bed time and as needed and he/she wore pull ups. Review of the nurse's notes revealed staff documented the following:	F 323		

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F 323	Continued From page 12 On 11/11/12 at 5:48 P.M. staff documented the resident was confused and in the living room with lights off and pants to his/her knees. No new interventions were added to the care plan to prevent the resident from falling. On 11/17/12 at 2:43 A.M. staff documented the resident was confused and thought there was water on the floor when there was not. On 11/27/12 at 9:10 A.M. staff documented the resident was very slow to comprehend things and required assistance to dress. On 12/09/12 at 2:00 A.M. staff documented the resident fell walking and tripped over a humidifier and sustained a skin tear to his/her right elbow and scrape on his/her right knee. Staff instructed the resident to turn on the lamp before getting up, but did not initiate any other fall interventions. On 12/12/12 at 4:43 A.M. staff documented the resident fell in the bathroom. Staff needed to check the resident more often, but did not specify how often and did not initiate any new fall interventions. On 2/10/13 at 6:30 P.M. staff documented the resident fell in his/her room and received a skin tear while attempting to transfer to the wheelchair. Staff initiated the intervention for self locking brakes on the wheelchair. On 2/12/13 at 4:15 A.M. staff observed the resident on the floor by his/her bed. The resident told staff his/her legs went out and caused the fall. Staff assessed the resident and assisted him/her to the bed. Staff found no injuries at that time. At 10:27 A.M. the resident complained of left thigh, knee and ankle pain. Staff were unclear of exactly what was hurting the resident. The physician was notified and an order was received to X-ray the resident. Further review of the resident's clinical record	F 323		

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revealed the resident was admitted to an acute care hospital for a fractured right hip and returned to the facility on 2/25/13 at 1:30 P.M. with an order to be 50 percent weight bearing on the right leg.

Review of the nurse's notes after the resident returned from the hospital with the broken hip revealed staff documented the following:

On 3/2/13 at 10:37 A.M. staff documented the resident frequently attempted to transfer independently and had hallucinations. The record lacked evidence of new interventions to the care plan.

On 3/6/13 at 4:00 A.M. staff documented the resident fell in his/her room while walking and suffered an abrasion to the top of the right foot. The resident was observed on the floor in front of the recliner. The call light was in place on the bed within reach. Staff assisted the resident up to the toilet and then transferred him/her back to bed. Staff turned the night light on in the room. No new interventions were added to the care plan.
On 3/27/13 at 9:30 P.M. staff documented the resident fell in his/her room while attempting to transfer without staff assistance and fell on the floor in front of the wheelchair which resulted in a skin tear to his/her left forearm. Staff did not add fall interventions to the resident's care plan.
On 4/18/13 at 6:30 A.M. staff documented the resident fell in the hallway while walking and lost his/her balance. The resident told staff he/she ambulated in the hall alone to see how long it would take staff to yell at him/her. Staff did not add any new fall interventions to the care plan.
On 4/28/13 at 1:12 P.M. staff documented the resident fell in his/her room while walking and received a bruise to his/her right elbow. Staff

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documented the severely impaired resident was noncompliant with asking staff for assistance. Staff instructed the resident to use the call light. No new interventions were added to the care plan to prevent further falls.
On 7/8/13 at 8:56 P.M. staff documented the resident fell in his/her room walking without staff assistance and the resident reported the fall was caused by a loss of balance. Staff reminded the resident to wait for assistance and use the call light. Staff did not add any new interventions to the care plan to prevent further falls.
On 7/14/13 at 5:15 P.M. staff documented the resident fell while attempting to toilet himself/herself. The resident fell in the bathroom. Staff re-educated the resident to call for help and no new interventions were added to the care plan. Staff did not assess the resident's voiding pattern to establish the need for a new scheduled toileting plan.
On 7/24/13 at 8:00 P.M. staff documented the resident fell in the bathroom attempting to toilet himself/herself and suffered a nickel sized bump on the back of his/her head. Staff observed the resident on the bathroom floor under the sink with his/her pants pulled partially down and bowel movement on the ground were the resident sat. Staff emphasized to the cognitively impaired resident the importance of using the call light for assistance. Staff did not assess the resident's bowel and bladder voiding pattern or add any new interventions to the care plan to prevent further falls.

Observation on 8/8/13 at 12:07 P.M. revealed the resident sat in the recliner in his/her room.

Observation on 8/8/13 at 12:08 P.M. of the nurse's desk revealed a small monitor with a picture of the resident's empty bed. The monitor

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did not display a picture of the resident who sat in the recliner.

Observation on 8/8/13 at 12:44 P.M. revealed the resident sat in the wheelchair in his/her room. Direct care staff T asked the resident if he/she needed to use the toilet. The resident told staff he/she was elderly and did not always know when he/she needed to use the toilet and asked when the next opportunity to toilet would be. Staff informed the resident they would offer to toilet him/her before the next meal. Staff did not offer anymore encouragement to toilet the resident, but instead placed the gait belt around the resident and transferred the resident using extensive assistance and frequent cues to move his/her feet and sit down on the bed. Staff lowered the bed down to the floor. Staff did not place a fall mat by the resident's bed on the floor.

During interview on 8/8/13 at 11:34 A.M. direct care staff U reported the resident was unsteady on his/her feet, leaned to one side and liked to do things on his/her own without calling staff for help. The video camera monitor at the nurse's desk was used by staff at night to see the resident while in bed. Staff kept the wheelchair away from the resident so he/she would be less eager to get up without staff assistance. When the resident was in bed, staff lower the bed down to the floor. The resident had self locking brakes on the wheelchair.

During interview on 8/8/13 at 11:45 A.M. licensed nurse I reported the resident was high risk for falls, had balance issues, leaned to the left side and was not aware of safety and frequently tried to transfer independently which caused falls. When a resident fell the nurse assessed the resident and filled out an incident report in the

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computer and the system made staff put a fall intervention in place before the computer allowed the nurse out of the program. The resident had hallucinations in the past and was confused. The resident had a pad alarm which staff discontinued back in December 2012. Staff utilized fall interventions such as they lowered the bed all the way to the floor, the resident's room was as close as they could get it to the nurse's station the video monitor at night and toileting assistance. Staff reported the resident was frequently incontinent and did fall attempting to toilet independently. He/she acknowledged the voiding diary was incomplete and staff did not thoroughly assess the resident's incontinence to establish a voiding pattern.

During interview on 8/8/13 at 12:44 P.M. direct care staff T reported the resident was at risk for falls and staff provided extensive assistance for transfers, toileting the resident before and after meals, and the resident would call to toilet at other times or independently climb out of bed and try to get to the toilet.

During interview on 8/8/13 at 3:23 P.M. administrative nursing staff D reported the facility had tried to get rid of body alarms and there were only 2 pad alarms in the entire facility now. This resident had alarms which staff thought caused the resident more confusion so they discontinued them. Soon they planned to do a trial alarm with the resident that was not audible, but alerted staff to the pagers when the resident tried to get up. The facility did not have that alarm yet, but it was on order. Right now staff should lower the bed, use a landing strip mat by the bed and use the monitor/camera at night. Staff needed to put an appropriate intervention in place after each fall. Administrative staff D expected staff to attempt to

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F 323	Continued From page 17 educate the resident, but should have put more appropriate interventions in place after each time the resident fell and the care plan needed updated when the resident fell going to the toilet and was incontinent. The facility did not institute routine voiding diary use after a fall to determine a voiding pattern. Staff should complete a voiding diary upon the resident's admission, yearly and with significant changes. Staff should take the monitor with them during the night, but not during the day when the resident was out of bed. The care plan updated 5/10/13 lacked interventions for the monitoring of a fall landing mat. On 8/12/13 at 10:16 A.M. an interview was attempted with consultant physician II, however the physician was not available for interview. The facility provided a policy without a date entitled Fall Risk Assessment which directed staff to institute interventions for residents found to be at risk for falls. The facility failed to initiate timely and effective new interventions following this cognitively impaired resident's falls to prevent further falls resulting in a fracture and failed to utilize fall interventions as planned.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		

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F 329	Continued From page 18 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility identified a census of 85 residents. The sample included 5 residents for medication review. Based on observation, record review and interview the facility failed to effectively monitor medications for Black Boxed Warnings (BBW) for 4 (#53, #58, #28, #7) of the 5 residents reviewed for unnecessary medications. Findings included: - The Physician Order Recertification Sheet dated 5/20/13 listed the following diagnoses for resident #53: dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors and episodic mood disorder (a subtype of depression characterized by the inability to find pleasure in positive things combined with physical agitation, insomnia, or decreased appetite) and traumatic arthropathy (a joint affected by trauma, characterized by a fracture line through the joint, resulting in	F 329		

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hemorrhage, capsular swelling and distention, followed by adhesions, granulation tissue, and ossification of the joint).

The quarterly Minimum Data Set 3.0 with assessment reference date of 7/15/13 listed the Brief Interview for Mental Score as 7, which indicated severe cognitive impairment, mood score was 4 minimal depression, and had no behaviors. He/she had pain frequently which interfered with his/her day to day activities, rated pain worst at a 10 on 1 to 10 scale, with 10 being the highest score for pain. The resident received antidepressant (medication used in the treatment of depression and other conditions) and anti-psychotic (medication used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental and emotional conditions) medication daily.

The Care Area Assessment (CAA) dated 4/25/13 for delirium listed the resident was demented with rather volatile mood at times and could get quite agitated. He/she received medications for this to help keep his/her mood less explosive.

The CAA for behavior dated 4/25/13 noted staff redirected the resident when needed, the resident had a long standing history of delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue) and hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind).

The CAA for psychotropic medication (a prescription medication used to treat or manage a psychiatric symptom or challenging behavior) use

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dated 4/25/13 noted the resident received anti-psychotic and antidepressant medications. He/she needed the medications for quality of life and emotional comfort due to his/her long standing psychotic problems.

The care plan for potential for chronic pain dated 7/19/13 noted the pain was related to degenerative disc disease. Staff to describe the pain, document pain level, chart medication effectiveness, assist with repositioning, encourage rest periods, and position for comfort.

The Activities of Daily Living (ADL) care plan dated 6/29/13 and last reviewed on 7/19/13 noted for staff to assist with ADLs, related to dementia, and manifested by ADL participation. Assess the resident's cognitive level, note changes in functional level, and offer simple instructions to encourage the resident to participate. Staff to keep the call light in reach, toilet before and after meals, at bedtime, as needed and the first round of the night shift. The resident's family requested the overhead light in the room remain on at all times due to his/her poor vision and fearfulness of the dark. There was a half rail to the left side of the bed to assist the resident with positioning and promote independence.

The BBW care plan with the original date of 12/7/11, with most recent review date of 7/19/13 noted the nurses monitored the side effects of the identified medications, were able to identify the medications by listing on the Medication Administration Record ,and the red dot on the label of the medication, work with the physician on the effectiveness of the medication, review medications every 60 days for efficacy and side effects, and a goal of no adverse side effects from the medications. Medications listed:

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F 329	Continued From page 21 Mirtazapine, Norco/Lortab, Seroquel, and Fentanyl. Review of the August 2013 MAR and the physician recapitulation order sheet dated 5/20/13 identified the following medications with BBW: Mirtazapine 15 milligram (mg) one tab orally at hour of sleep (HS) for depression with start date of 6/27/11. Seroquel 25 mg orally at HS for psychotic mood disorder with start date of the medication of 6/27/11, Fentanyl 12 micrograms per hour (mcg/hr) 1 patch transdermal every 3 days at 11:00 A.M. for chronic pain with start date of 12/28/11. Review of Drug Information Handbook for Nursing dated 2011, 12 th Edition, listed the following BBWs: Seroquel warning/precautions [U.S. Blacked Boxed Warning]: " Elderly patient with dementia-related psychosis treated with anti-psychotic are at an increased risk of death compared to placebo". Fentanyl transdermal patches warning/precautions [U.S. Black Boxed Warning]: " Indicated for the management of persistent moderate-to-severe pain when around the clock pain control is needed for an extended time period. Should only be used for patients who are already receiving opioid therapy, are opioid tolerant, and who require a total daily dose equivalent to 25 mcg/hr transferal patch. Contraindicated in patients who are not opioid tolerant, in the management of short term analgesia, or in the management of postoperative pain. Should be applied only to intact skin. Use of a patch that has been cut, damaged, or altered in any way may result in overdose".	F 329		

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F 329	Continued From page 22 Observation on 8/7/13 at 7:10 A.M. revealed the resident sat in the bathroom, the call light was on. Staff stopped in and told him/her they would be right back to help. The resident voiced understanding. On 8/7/13 at 3:10 P.M. the resident propelled self out to the nurse's station, questioning when he/she got his/her next pain pill. The resident smiled and was pleasant to staff. Observation on 8/8/13 at 7:45 A.M. revealed the resident exercised with staff supervision. The resident smiled, cheerful and said he/she loved breakfast and wanted to ask for seconds but knew it would go right to his/her middle. Interview with direct care staff P on 8/7/13 at 3:46 P.M. said the resident sometimes got anxious, impatient, or upset with staff especially when he/she wanted a pain pill and it was not time for it yet but otherwise did not really show any other behaviors. Interview on 8/7/13 with licensed nursing staff I at 4:42 P.M. said the staff wrote the BBW on the MAR and only listed the medication but not the BBW for that medication on the care plan. The undated facility policy for Black Box Warning said it was "to ensue that adverse side effects are monitored on all medications listed under this category". The policy failed to identify care planning for the side effects for BBW medications. The facility failed to monitor and care plan for Black Boxed Warning side effects for Seroquel and Fentanyl for this cognitively impaired	F 329		

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F 329	Continued From page 23 resident. - The Physician Order Recertification Sheet dated 5/20/13 listed the following diagnoses for resident #58: dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance, type 2 diabetes (when the body can not use glucose, there was not enough insulin made or the body can not respond to the insulin), and venous thrombosis (an abnormal condition in which a clot develops within a blood vessel). The quarterly Minimum Data Set (MDS) 3.0 with the assessment reference date of 7/1/13 listed the Brief Interview for Mental Status score of 13 which indicated he/she was cognitively intact. The resident exhibited no behaviors and had a mood score of 1 which indicated minimal depression. The resident received anti-psychotic, antidepressant, and anticoagulant medications. The Care Area Assessment (CAA) dated 4/10/13 for psychotropic medication use noted the resident received anti-psychotic and antidepressants medications. Refer to the nurses notes, psychiatric mediation evaluations, and behaviors and physician progress notes when the facility attempted to decrease medications in the past, the resident became very agitated and even more delusional and it affected his/her quality of life. The care plan for Black Boxed Warnings (BBW) last updated on 7/5/12 noted for staff to monitor	F 329		

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the side effects of the identified medications, to be able to identify the medication by the listing on the Medication Administration Record (MAR) and the red dot on the medication label, to work with physician on effectiveness of medications, and review medications with the physician every 60 days. The medications listed on the care plan were Coumadin, Metformin, Tylenol/Acetaminophen, Celexa, and Seroquel.

The care plan for Coumadin/Warfarin used for history of deep vein thrombosis was last dated 7/5/13. Staff to assess arms and legs for redness and pain, give medication as ordered, observe for side effects such as hemorrhage, dermatitis, urticaria, anorexia, hematuria, nausea/vomiting, headache, and report leg pain/redness.

Review of the August 2013 MAR and the physician recapitulation order sheet dated 5/20/13 identified the following medications with BBW:
Metformin 500 milligrams (mg) one tab orally twice daily for diabetes mellitus with start date of 4/6/11
Celexa 10 mg one tab at hour of sleep for depression with start date of 4/21/11
Warfarin 5 mg one tablet at 6:30 P.M. for thrombosis (clot) with start date of 4/18/12
Seroquel 50 mg one tab twice daily at 8:00 A.M. and 9:00 P.M.. for psychosis with start date of 3/8/12

Review of Drug Information Handbook for Nursing dated 2011, 12 th Edition, listed the following BBWs:
Metformin warning/precautions [U.S. Black Boxed Warning]: "Lactic acidosis (condition of too much acid in the body) is a rare, but potentially severe consequence of therapy with metformin".

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F 329	Continued From page 25 Warfarin/Coumadin warning/precautions [U.S. Black Boxed Warning]: "Risk factors for bleeding include high intensity anticoagulation (INR, a laboratory blood test--international normalized ratio), variable INRs, history of gastrointestinal bleeding (bleeding in the stomach or digestive tract), hypertension (high blood pressure), anemia (a condition with out enough healthy red blood cells to carry adequate oxygen to the body tissue), malignancy (abnormal rapid growth of cells/cancerous growth), trauma, renal insufficiency (inability of the kidneys to excrete waste), drug to drug interactions, long duration of therapy or known genetic deficiency in CYP2C9 (human enzyme) activity". Observation on 8/7/13 at 7:08 A.M. revealed the resident up and about in room, combing hair and dressed and said he/she was going down to the dining room soon. The resident had a steady gait. Observed the resident on 8/7/13 at 3:52 P.M. resting quietly in bed, eyes closed. Observation on 8/8/13 at 7:38 A.M. revealed the resident sat in a chair in his/her room, had a housecoat on and said he/she was waiting for a bath. Interview on 8/7/13 with licensed nursing staff I at 4:42 P.M. said the staff wrote the BBW on the MAR and only list the medication but not the BBW for that medication on the care plan. The undated facility policy for Black Box Warning said it was "to ensue that adverse side effects are monitored on all medications listed under this category". The policy failed to identify care	F 329		

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F 329	Continued From page 26 planning for the side effects for BBW medications. The facility failed to monitor and care plan for Black Boxed Warning side effects for Metformin and Warfarin for this resident. - The electronic diagnoses for resident #28 dated 1-24-2012 documented Atrial Fibrillation (rapid, irregular heart beat), Diverticulitis Colon without Hemorrhage (inflammation of the diverticulum, in the colon, which causes pain and disturbance in bowel function), Anxiety state (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Esophageal reflux (a condition in which the stomach contents leak backwards from the stomach into the esophagus), Hypertension (elevated blood pressure), Hyperlipidemia (condition of elevated blood lipid levels), Salivary Secretion, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), and Malignant Neoplasm Colon (tumor of the colon). The Quarterly Minimum Data Set 3.0 (MDS) assessment dated 7-22-2013 documented a Brief Interview of Mental Status (BIMS) summary score of 7 indicating severe impairment of cognition. The MDS documented the resident felt down, depressed or hopeless, tired or having little energy. No behavioral symptoms, rejection or care, or wandering behaviors documented. The MDS documented diagnosis Anxiety disorder and Depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) (other than Bipolar) and medications resident received in the last seven days included Antianxiety, Antidepressant, and Anticoagulant medications.	F 329		

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F 329	Continued From page 27 The Care Area Assessment (CAA) for Delirium (sudden severe confusion, disorientation and restlessness) dated 11-14-2012 documented the resident had no signs of delirium. The resident did have cognition loss but that had occurred slowly. The CAA for Cognitive Loss dated 11-14-12 documented the resident had episodes of confusion but no delirium noted. The resident was normally alert and oriented and was forgetful at times and needed cues. This was expected with his/her Alzheimer's diagnosis. The CAA for Psychosocial Well-Being dated 11-14-12 documented the resident did have anxiety at times. He/she often complained of being nauseated or ill and staff felt at those times it was usually anxiety. He/she could go from feeling fine to not very well, quickly and if given one on one attention, staff could generally coax him/her to get up and dress and eat and then he/she felt fine and was pleasant. The resident took scheduled ativan (used to treat anxiety) and was on antidepressant. The CAA for Psychotropic Med Use dated 11-14-12 documented the resident had a long history with depression and anxiety per family. The resident benefited greatly with medication and was able to function at his/her fullest potential. The Electronic Physicians Orders dated 5-1-2012 documented Ativan 0.5 milligrams tablet by mouth twice a day for Anxiety--teeth grinding; 5-14-2012 Mirtazapine 15 milligram tablet by mouth daily at bedtime for Depression Black Box Warning: carefully observe patient for worsening;	F 329		

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6-19-2013 Coumadin 2.5 milligram tablet by mouth six times a week Friday, Saturday, Sunday, Thursday, Tuesday and Wednesday for Atrial Fibrillation Black Box Warning: can cause major or fatal bleeding. Monitor INR regularly. Tell caregivers to watch for signs of bleeding or abnormal bruising-notify MD immediately;
6-24-2013 Warfarin Sodium 2.5 milligram Tablet (2 tablet/5 milligrams) by mouth one time a week Monday for Atrial Fibrillation Black Box Warning: can cause major or fatal bleeding. Monitor INR regularly. Tell caregivers to watch for signs of bleeding or abnormal bruising-notify MD immediately.

The Care Plan for Black Box Warnings (BBW) Medications dated 12/23/2011 documented monitor the side effects of the identified medications, to be able to identify the medications by the listing on the MAR they were highlighted in red, work with physicians on effectiveness of medication(s), review medications with physician every 60 days for efficacy and side effects for Tylenol, Remeron, Coumadin, Lortab. The facility failed to care plan specific side effects for listed BBW medication.

Observation dated 8-6-2013 at 4:02 P.M. revealed the resident ambulated in the hallway with his/her walker. Resident was walking to the singing activity and then actively participated.

Observation dated 8-7-2013 at 7:28 A.M. revealed the resident ate breakfast without difficulty. At 11:45 A.M. the resident ate lunch without difficulty.

Licensed staff I on 8-8-13 at 2:52 P.M. stated, Black Box Warnings were on the MAR, and in the care plan medications were just listed and had no

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specific side effects.

The undated facility provided policy and procedure Black Box Warning did not address care planing black box warning side effects.

The facility failed to care plan for the side effects of the BBW medications.

- The electronic record for resident #7 documented diagnoses of Depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness), Anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and Mild Bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods).

The Annual Minimum Data Set (MDS) 3.0 dated 5/20/13 revealed a Brief Interview for Mental Status score of 10 (indicated moderately impaired cognition).

The Care Area Assessment (CAA) dated 2/25/13 for mood revealed impaired daily decision making.

Psychotropic medication CAA dated 2/25/13 revealed a long standing history of severe anxiety and depression.

The signed medication recertification dated 5/20/13 revealed Depakote (a medication given for severe high and low moods) by mouth twice a day which had a Black Box Warning (BBW) of nonspecific symptoms of malaise (vague uneasy

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F 329	Continued From page 30 feeling of body weakness, distress or discomfort), fever (elevated temperature), anorexia, facial edema and to perform liver function test prior to therapy and at frequent intervals for the first 6 months. Lexi-Comp's Drug Information Handbook for Nursing, 12 th Edition, noted the following Black Box warning for Depakote: Hepatic failure resulting in fatalities had occurred in patients. The revised care plan dated 5/24/13 for medication with a BBW, included staff were able to identify the medication by the listing on the MAR, and review medication with the physician every 60 days for efficacy and side effects. The care plan did not have the black box warning side effects listed for the medication. Observation on 8/8/13 at 9:15 A.M. the resident sat in the wheelchair in the hallway and called for a family member by name. Staff reassured the resident. Observation on 8/9/13 at 8:05 A.M. the resident sat in the wheelchair in the dining room and was assisted by staff with the breakfast meal. Licensed staff I on 8-8-13 at 2:52 P.M. stated, Black Box Warnings were on the MAR, and in the care plan medications were just listed and had no specific side effects. The undated facility provided policy and procedure Black Box Warning did not address care planing black box warning side effects. The facility failed to care plan for the side effects of the BBW medications.	F 329		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		

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F 425 SS=D	Continued From page 31 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This Requirement is not met as evidenced by: The facility identified a census of 85 residents. Medication administration included 9 residents. Based on observation, record review, and interview, the facility failed to accurately transcribe a medication order to the Medication Administration Record (MAR) for 1 (#4) resident of the sample. Findings included: - The electronic physician's order dated 4/5/11 for resident #4, revealed and order for Hyoscyamine Sulfate elixir 0.25 milligrams per enteral tube four times a day as needed for increased secretions.	F 425		

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F 425	Continued From page 32 The electronic MAR revealed Hyoscyamine Sulfate elixir 0.25 milligrams per mouth four times a day, instead of the enteral tube. Observation on 8/6/13 at 2:00 P.M. licensed staff H prepared and administered Hyoscyamine Sulfate elixir per enteral tube. Interview on 8/6/13 at 2:00 P.M. licensed staff H stated we have not given anything by mouth for a long time to this resident. Administrative staff B on 8/7/13 at 10:30 A.M. stated the medication electronic charting started in April 2011. He/she confirmed the physician's order dated 4/5/11 listed the route as the enteral tube. Administrative staff B on 8/7/13 at 11:05 A.M. stated when the order was transcribed into the MAR from the physician's order the computer automatically assigned a route. The nurse did not correct the automatically assigned route to the enteral tube as ordered. The facility did not have a policy for the transcription of physician's orders. The facility failed to correctly transcribe a physician's order to the MAR.	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		

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F 428	Continued From page 33 nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility identified a census of 85 residents. The sample included 5 residents for medication review. Based on observation, record review and interview the facility failed to effectively monitor medications for Black Boxed Warnings (BBW) for 4 (#53, #58, #28, #7) of the 5 residents reviewed for unnecessary medications. Findings included: - The Physician Order Recertification Sheet dated 5/20/13 listed the following diagnoses for resident #53: dementia (progressive mental disorder characterized by failing memory, confusion) with behaviors and episodic mood disorder (a subtype of depression characterized by the inability to find pleasure in positive things combined with physical agitation, insomnia, or decreased appetite) and traumatic arthropathy (a joint affected by trauma, characterized by a fracture line through the joint, resulting in hemorrhage, capsular swelling and distention, followed by adhesions, granulation tissue, and ossification of the joint). The quarterly Minimum Data Set 3.0 with assessment reference date of 7/15/13 listed the Brief Interview for Mental Score as 7, which indicated severe cognitive impairment, mood score was 4 minimal depression, and had no behaviors. He/she had pain frequently which interfered with his/her day to day activities, rated pain worst at a 10 on 1 to 10 scale, with 10 being	F 428		

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the highest score for pain. The resident received antidepressant (medication used in the treatment of depression and other conditions) and anti-psychotic (medication used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental and emotional conditions) medication daily.

The Care Area Assessment (CAA) dated 4/25/13 for delirium listed the resident was demented with rather volatile mood at times and could get quite agitated. He/she received medications for this to help keep his/her mood less explosive.

The CAA for behavior dated 4/25/13 noted staff redirected the resident when needed, the resident had long standing history of delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue) and hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind).

The CAA for psychotropic medication (a prescription medication used to treat or manage a psychiatric symptom or challenging behavior) use dated 4/25/13 noted the resident received anti-psychotic and antidepressant medications. He/she needed the medications for quality of life and emotional comfort due to his/her long standing psychotic problems.

The care plan for potential for chronic pain dated 7/19/13 noted the pain was related to degenerative disc disease, Staff to describe the pain, document pain level, chart medication effectiveness, assist with repositioning, encourage rest periods, and position for comfort.

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F 428	Continued From page 35 The Activities of Daily Living (ADL) care plan dated 6/29/13 and last reviewed on 7/19/13 noted for staff to assist with ADLs, related to dementia, and manifested by ADL participation. Assess the resident's cognitive level, note changes in functional level, and offer simple instructions to encourage the resident to participate. Staff to keep the call light in reach, toilet before and after meals, at bedtime, as needed and the first round of the night shift. The resident's family requested the overhead light in the room remain on at all times due to his/her poor vision and fearfulness of the dark. There was a half rail to the left side of the bed to assist the resident with positioning and promote independence. The BBW care plan with the original date of 12/7/11, with most recent review date of 7/19/13 noted the nurses monitored the side effects of the identified medications, were able to identify the medications by listing on the Medication Administration Record and the red dot on the label of the medication, work with the physician on the effectiveness of the medication, review medications every 60 days for efficacy and side effects, and a goal of no adverse side effects from the medications. Medications listed: Mirtazapine, Norco/Lortab, Seroquel, and Fentanyl. Review of the August 2013 MAR and the physician recapitulation order sheet dated 5/20/13 identified the following medications with BBW: Mirtazapine 15 milligram (mg) one tab orally at hour of sleep (HS) for depression with start date of 6/27/11. Seroquel 25 mg orally at HS for psychotic mood disorder with start date of the medication of 6/27/11. Fentanyl 12 micrograms per hour (mcg/hr) 1	F 428		

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patch transdermal every 3 days at 11:00 A.M. for chronic pain with start date of 12/28/11.

Review of Drug Information Handbook for Nursing dated 2011, 12 th Edition, listed the following BBWs:
Seroquel warning/precautions [U.S. Blacked Boxed Warning]: " Elderly patient with dementia-related psychosis treated with anti-psychotic are at an increased risk of death compared to placebo".

Fentanyl transdermal patches warning/precautions [U.S. Blacked Boxed Warning]: "Indicated for the management of persistent moderate-to-severe pain when around the clock pain control is needed for an extended time period. Should only be used for patients who are already receiving opioid therapy, are opioid tolerant, and who require a total daily dose equivalent to 25 mcg/hr transferal patch. Contraindicated in patients who are not opioid tolerant, in the management of short term analgesia, or in the management of postoperative pain. Should be applied only to intact skin. Use of a patch that has been cut, damaged, or altered in any way may result in overdose".

Review of the Drug Regimen Review dated monthly from 7/19/12 to 7/3/13 revealed no documentation related to BBW monitoring.

Observation on 8/7/13 at 7:10 A.M. revealed the resident sat in the bathroom, the call light was on. Staff stopped in and told him/her they would be right back to help. The resident voiced understanding.

On 8/7/13 at 3:10 P.M. the resident propelled self out to the nurse's station, questioning when

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he/she got his/her next pain pill. The resident smiled and was pleasant to staff.

Observation on 8/8/13 at 7:45 A.M. revealed the resident exercised with staff supervision. The resident smiled, cheerful and said he/she loved breakfast and wanted to ask for seconds but knew it would go right to his/her middle.

Interview with direct care staff P on 8/7/13 at 3:46 P.M. said the resident sometimes got anxious, impatient, or upset with staff especially when he/she wanted a pain pill and it was not time for it yet but otherwise did not really show any other behaviors.

Interview on 8/7/13 with licensed nursing staff I at 4:42 P.M. said the staff wrote the BBW on the MAR and only listed the medication but not the BBW for that medication on the care plan.

An interview on 8/8/13 at 2:55 P.M. with consultant HH said he/she reviewed the residents' chart for unnecessary medications monthly, collected data from the physician's order sheet, laboratory results, physician progress notes, and the history and physical. He/she did not review the residents' care plans.

The undated facility policy for Black Box Warning said it was "to ensue that adverse side effects are monitored on all medications listed under this category". The policy failed to identify care planning for the side effects for BBW medications.

Consultant HH failed to identify the irregularity of the facility not monitoring for Black Boxed Warning side effects for Seroquel and Fentanyl for this cognitively impaired resident.

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- The Physician Order Recertification Sheet dated 5/20/13 listed the following diagnoses for resident #58: dementia (progressive mental disorder characterized by failing memory, confusion) with behavior disturbance, type 2 diabetes (when the body can not use glucose, there was not enough insulin made or the body can not respond to the insulin), and venous thrombosis (an abnormal condition in which a clot develops within a blood vessel).

The quarterly Minimum Data Set (MDS) 3.0 with the assessment reference date of 7/1/13 listed the Brief Interview for Mental Status score of 13 which indicated he/she was cognitively intact. The resident exhibited no behaviors and had a mood score of 1 which indicated minimal depression. The resident received anti-psychotic, antidepressant, and anticoagulant medications.

The Care Area Assessment (CAA) dated 4/10/13 for psychotropic medication use noted the resident received anti-psychotic and antidepressants medications. Refer to the nurses notes, psychiatric mediation evaluations, and behaviors and physician progress notes when the facility attempted to decrease medications in the past, the resident became very agitated and even more delusional and it affected his/her quality of life.

The care plan for Black Boxed Warnings (BBW) last updated on 7/5/12 noted for staff to monitor the side effects of the identified medications, to be able to identify the medication by the listing on the Medication Administration Record (MAR) and the red dot on the medication label, to work with physician on effectiveness of medications, and

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F 428	Continued From page 39 review medications with the physician every 60 days. The medications listed on the care plan were Coumadin, Metformin, Tylenol/Acetaminophen, Celexa, and Seroquel. The care plan for Coumadin/Warfarin used for history of deep vein thrombosis was last dated 7/5/13. Staff to assess arms and legs for redness and pain, give medication as ordered, observe for side effects such as hemorrhage, dermatitis, urticaria, anorexia, hematuria, nausea/vomiting, headache, and report leg pain/redness. Review of the August 2013 MAR and the physician recapitulation order sheet dated 5/20/13 identified the following medications with BBW: Metformin 500 milligrams (mg) one tab orally twice daily for diabetes mellitus with start date of 4/6/11 Celexa 10 mg one tab at hour of sleep for depression with start date of 4/21/11 Warfarin 5 mg one tablet at 6:30 P.M. for thrombosis (clot) with start date of 4/18/12 Seroquel 50 mg one tab twice daily at 8:00 A.M. and 9:00 P.M.. for psychosis with start date of 3/8/12 Review of Drug Information Handbook for Nursing dated 2011, 12 th Edition, listed the following BBWs: Metformin warning/precautions [U.S. Black Boxed Warning]: "Lactic acidosis (condition of too much acid in the body) is a rare, but potentially severe consequence of therapy with metformin". Warfarin/Coumadin warning/precautions [U.S. Black Boxed Warning]: "Risk factors for bleeding include high intensity anticoagulation (INR, a laboratory blood test--international normalized	F 428		

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ratio), variable INRs, history of gastrointestinal bleeding (bleeding in the stomach or digestive tract), hypertension (high blood pressure), anemia (a condition with out enough healthy red blood cells to carry adequate oxygen to the body tissue), malignancy (abnormal rapid growth of cells/cancerous growth), trauma, renal insufficiency (inability of the kidneys to excrete waste), drug to drug interactions, long duration of therapy or known genetic deficiency in CYP2C9 (human enzyme) activity".

Review of the Drug Regimen Review monthly from 8/10/12 to 7/3/13 revealed on 8/10/12 pharmacy consultant HH noted BBW medication monitored but no further notations noted in the documentation.

Observation on 8/7/13 at 7:08 A.M. revealed the resident up and about in room, combing hair and dressed and said he/she was going down to the dining room soon. The resident had a steady gait.

Observed the resident on 8/7/13 at 3:52 P.M. resting quietly in bed, eyes closed.

Observation on 8/8/13 at 7:38 A.M. revealed the resident sat in a chair in his/her room, had a housecoat on and said he/she was waiting for a bath.

Interview on 8/7/13 with licensed nursing staff I at 4:42 P.M. said the staff wrote the BBW on the MAR and only list the medication but not the BBW for that medication on the care plan.

An interview on 8/8/13 at 2:55 P.M. with consultant HH said he/she reviewed the residents' chart for unnecessary medications

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monthly, collected data from the physician's order sheet, laboratory results, physician progress notes, and the history and physical. He/she did not review the residents' care plans.

The undated facility policy for Black Box Warning said it was "to ensue that adverse side effects are monitored on all medications listed under this category". The policy failed to identify care planning for the side effects for BBW medications.

Consultant HH failed to identify the irregularity of the facility not monitoring for Black Boxed Warning side effects for Metformin and Warfarin for this resident.

- The electronic diagnoses for resident #28 dated 1-24-2012 documented Atrial Fibrillation (rapid, irregular heart beat), Diverticulitis Colon without Hemorrhage (inflammation of the diverticulum, in the colon, which causes pain and disturbance in bowel function), Anxiety state (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Esophageal reflux (a condition in which the stomach contents leak backwards from the stomach into the esophagus), Hypertension (elevated blood pressure), Hyperlipidemia (condition of elevated blood lipid levels), Salivary Secretion, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), and Malignant Neoplasm Colon (tumor of the colon).

The Quarterly Minimum Data Set 3.0 (MDS) assessment dated 7-22-2013 documented a Brief Interview of Mental Status score of 7 indicating severe impairment of cognition. The MDS documented the resident felt down, depressed or

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hopeless, tired or having little energy. No behavioral symptoms, rejection or care or wandering documented. The MDS documented diagnosis Anxiety disorder and Depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) (other than Bipolar) and medications resident received in the last seven days included Antianxiety, Antidepressant, and Anticoagulant medications.

The Care Area Assessment (CAA) for Delirium (sudden severe confusion, disorientation and restlessness) dated 11-14-2012 documented the resident had no signs of delirium. The resident did have cognition loss but had occurred slowly.

The CAA for Cognitive Loss dated 11-14-12 documented the resident had episodes of confusion but no delirium noted. The resident was normally alert and oriented and was forgetful at times and needed cues. This was expected with his/her Alzheimer's diagnosis.

The CAA for Psychosocial Well-Being dated 11-14-12 documented the resident did have anxiety at times. He/she often complained of being nauseated or ill and staff felt at those times it was usually anxiety. He/she could go from feeling fine to not very well, quickly and if given one on one attention, staff could generally coax him/her to get up, dress and eat and then he/she felt fine and was pleasant. The resident took scheduled ativan (used to treat anxiety) and was on antidepressant.

The CAA for Psychotropic Med Use dated 11-14-12 documented the resident had a long history with depression and anxiety per family. The resident benefited greatly with medication

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F 428	Continued From page 43 and was able to function at his/her fullest potential. The Electronic Physicians Orders dated 5-1-2012 documented Ativan 0.5 milligrams tablet by mouth twice a day for Anxiety--teeth grinding; 5-14-2012 Mirtazapine 15 milligram tablet by mouth daily at bedtime for Depression Black Box Warning: carefully observe patient for worsening; 6-19-2013 Coumadin 2.5 milligram tablet by mouth six times a week Friday, Saturday, Sunday, Thursday, Tuesday and Wednesday for Atrial Fibrillation Black Box Warning: can cause major or fatal bleeding. Monitor INR regularly. Tell caregivers to watch for signs of bleeding or abnormal bruising-notify MD immediately; 6-24-2013 Warfarin Sodium 2.5 milligram Tablet (2 tablet/5 milligrams) by mouth one time a week Monday for Atrial Fibrillation Black Box Warning: can cause major or fatal bleeding. Monitor INR regularly. Tell caregivers to watch for signs of bleeding or abnormal bruising-notify MD immediately. Record review on 8-12-13 revealed DRR Consultant Pharmacist Review from 1-18-2012 to 7-3-13, did not identify the need for BBW including side effects on the care plan. The Care Plan for Black Box Warnings (BBW) Medications dated 12/23/2011 documented monitor the side effects of the identified medications, to be able to identify the medications by the listing on the MAR they were highlighted in red, work with physicians on effectiveness of medication(s), review medications with physician every 60 days for efficacy and side effects for Tylenol, Remeron, Coumadin, Lortab. The facility failed to care plan specific side effects for listed BBW medication.	F 428		

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F 428	Continued From page 44 Observation dated 8-6-2013 at 4:02 P.M. revealed the resident ambulated in the hallway with his/her walker. Resident was walking to the singing activity and then actively participated. Observation dated 8-7-2013 at 7:28 A.M. revealed the resident ate breakfast without difficulty. At 11:45 A.M. the resident ate lunch without difficulty. Licensed staff I on 8-8-13 at 2:52 P.M. stated, Black Box Warnings were on the MAR, and on the care plan medications were just listed and had no specific side effects. Consultant staff HH on 8-8-13 at 2:55 P.M. stated the resident's chart was reviewed for unnecessary medications monthly. The data was collected from the Physician's order sheet, laboratory results, physician progress notes, and history and physical. The residents' care plans were done by nursing service and not reviewed by him/her.. The undated facility provided policy and procedure Black Box Warning did not address care planning black box warning side effects. The facility's consultant pharmacist failed to identify the need to address BBW's on the care plan. - The electronic record for resident #7 documented diagnoses of Depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness), Anxiety (a mental or emotional	F 428		

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reaction characterized by apprehension, uncertainty and irrational fear), and Mild Bipolar disorder(a major mental illness that causes people to have episodes of severe high and low moods).

The Annual Minimum Data Set (MDS) 3.0 dated 5/20/13 revealed a Brief Interview for Mental Status score of 10 (indicated moderately impaired cognition).

The Care Area Assessment (CAA) dated 2/25/13 for mood revealed impaired daily decision making.

CAA for Psychotropic medication dated 2/25/13 documented a long standing history of severe anxiety and depression.

The signed medication recertification by Pharmacy consultant HH dated 5/20/13 revealed Depakote (a medication given for severe high and low moods) by mouth twice a day which had a Black Box Warning (BBW) of nonspecific symptoms of malaise (vague uneasy feeling of body weakness, distress or discomfort), fever (elevated temperature), anorexia, facial edema and to perform liver function test prior to therapy and at frequent intervals for the first 6 months.

The review of the Drug Regime Review dated 4/22/13, 5/13/13, 6/12/13, and 7/3/13 failed to address the lack of BBW side effects on the care plan.

Lexi-Comp's Drug Information Handbook for Nursing, 12 th Edition, noted the following Black Box warning for Depakote: Hepatic failure resulting in fatalities had occurred in patients.

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F 428	Continued From page 46 Observation on 8/8/13 at 9:15 A.M. the resident sat in the wheelchair in the hallway and called for a family member by name. Staff reassured the resident. Licensed staff I on 8-8-13 at 2:52 P.M. stated, Black Box Warnings were on the MAR, and on the care plan medications were just listed and had no specific side effects. Consultant staff HH on 8-8-13 at 2:55 P.M. stated the resident's chart was reviewed for unnecessary medications monthly. The data was collected from the Physician's order sheet, laboratory results, physician progress notes, and history and physical. The residents' care plans were done by nursing service and not reviewed. The undated facility provided policy and procedure Black Box Warning did not address care planning black box warning side effects. The facility's consultant pharmacist failed to identify the need to address BBW's on the care plan.	F 428		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This Requirement is not met as evidenced by: The facility reported a census of 85 residents . Based on observation and interview the pager system for call light notification for two bathroom call lights, on one of four hallways, did not trigger the Certified Nurse Assistant (CNA) or licensed	F 463		

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F 463	Continued From page 47 nurses' pager and did not trigger a visual light on the room panel located at the nurses' station for 2 of 4 days on site of the survey. Findings included: - Observation on 8/6/13 at 11:40 A.M. the bathroom call light for residents' #22 and #10, and an unsampled resident did not trigger the CNA or licensed staff pager. Observation on 8/8/13 at 10:59 A.M. the bathroom light for resident #22 and #10 was activated. The CNA and the licensed nurses' pagers did not trigger. The panel at the nurses' station did not light up with the room number. Licensed nurse I on 8/8/13 at 11:05 A.M. confirmed the call lights were not working appropriately. Administrative nursing staff D on 8/12/13 at 10:55 A.M. revealed he/she visited with maintenance staff EE and the call system was checked monthly. The facility failed to have a functional bathroom call light for a resident in this facility.	F 463		